Physician Related Services

- Mid-Level Practitioners
- Podiatrists
- Fall 2011 WebEx

Contacts

- Claims issues: general claims questions Ask ACS claims questions FIRST and they will redirect to appropriate State staff.

- ACS 800-624-3958

Other Resources for 1500 claims

- Claims issues: (i.e. timely filing)
  Brenda Beardslee
  Physician Claims Specialist
  406-444-3337
  BBeardslee2@mt.gov

- NDC & EPSDT claims issues
  Beverly Hertweck
  Physician Program Specialist
  406-444-9633
  bhertweck@mt.gov

- Bob Wallace
  Physician Program Section Supervisor
  406-444-5778
  bwallace@mt.gov

- General Program and/or Policy questions
  Connie Olson RN
  Physician Related Services Program Officer
  406-444-3995
  COlson2@mt.gov

Physician Related Services Website

- http://medicaidprovider.hhs.mt.gov/providerpages/providertype/27.shtml

Manual, Rules & Regulations, Fee Schedules, Provider Notices and Replacement Pages, Other Resources, Key Contacts, and Rebateable Manufacturers located on this website.

NEW PROVIDER ENROLLMENT OR EXISTING PROVIDER REENROLLMENT

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Physician

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Medicaid Rules/Regulations (Updated May 9, 2006)
Fee Schedules (Updated February 2, 2011)
Archived Fee Schedules (Updated February 8, 2010)
Notices and Replacement Pages (Updated February 23, 2011)
Other Resources (Updated February 2, 2011)
Remittance Advice Notice
Key Contacts (Updated December 20, 2010)
Rebateable Manufacturers (Updated August 24, 2010)

Provider Manuals

General Information For Providers
Medicaid billing manual with general information for all provider types.
04/2005

Physician Related Services
This manual has billing instructions specific to your provider type.
07/2008

Manuals

Mid-levels & Podiatrists **do not** have separate Provider Manuals. Information about these providers can be found in the Physician Related Services Manual

- Mid-levels and Podiatrists **do** have individual fee schedules for their provider type.

Information can be found on the Mid-level and Podiatrist websites.

- Mid-level Practitioner:
- http://medicaidprovider.hhs.mt.gov/providerpages/providertype/44.shtml

- Podiatrist
- http://medicaidprovider.hhs.mt.gov/providerpages/providertype/05.shtml

Fee schedules for mid-levels and podiatrists offer specific information for each of these two providers.

Information found on the fee schedule

- Fee schedules include information about some modifiers, a short description of the procedure code, date the codes is effective, how the fee is determined, whether a prior authorization is required, and information about global days.

- **If a valid, current code is not present, that code may be a non-covered service**

Mid-level definitions

- Administrative Rule 37.86.202 includes a variety of definitions. Included is:
- (5) "Mid-level practitioner" means the following professionals:
- (a) advanced practice registered nurse; and
- (b) physician assistant

“Advanced practice registered nurse” includes nurse practitioner, nurse anesthetist, nurse midwife and clinical nurse specialist.

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04/2005

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This manual has billing instructions specific to your provider type.
07/2008

Prescription Drug Program
This manual has information on prescriptions and limitations.
11/2004

Passport to Health Provider Handbook
Everything providers need to know to become a successful Passport provider.
09/2005

Montana Medicaid - Fee Schedule
Mid-Level
September 1, 2011

Definitions:

Modifier – When a modifier is present, this indicates system may have different reimbursement or code edits for that procedure code/modifier combination.
For example:
26 = professional component
TC = technical component

Description – Procedure code short description. You must refer to the appropriate official CPT-4, HCPCS or CDT-5 coding manual for complete definitions in order to assure correct coding.

Effective – This is the first date of service for which the listed fee is applicable. Fees for drugs, radiopharmaceuticals, blood products, immune globins, vaccines, and toxoids are reviewed and updated quarterly – effective dates that are greater than three months old indicate that there has been no fee change since that date.

Method – Source of fee determination
Fee Sched: Medicaid fee; not determined using RBRVS payment schedule
Medicare: Medicare-prevailing fee.
By Report (BR): Equals 47% of billed charges. (Physician administered drugs will be priced by NDC if no rate is present.)
Anes Value: Number of anesthesia base value units. This is added to the 15 min. time increment units and multiplied by the anesthesia conversion factor of $27.55.
RBRVS: Based on Medicare Relative Value Units (RVU's) x Montana Medicaid conversion factor x policy adjuster. Conversion factor for fiscal year 2012 is $33.23.
***If a valid, current code is not present, that code may be a non-covered service**

Fees The facility rate is paid to physicians/practitioners providing services in the following sites: hospitals, emergency rooms, ambulatory surgery centers, IHS provider based and IHS 638 free standing facilities, skilled nursing and nursing facilities, hospice, ambulance, inpatient psychiatric and partial psychiatric hospitals, psychiatric residential treatment centers, comprehensive inpatient rehab facilities, birthing centers and military treatment facilities. All other sites of service receive the office rate.
Procedures not normally done in the office are shown with the same facility rate, while those done in both locations have different rates.
Bundled services, which are covered but paid as part of a related service, are shown with an RBRVS method and a fee of $0.00.
Policy adjustments are applied to certain codes to increase or decrease reimbursement for the service.
Vaccines covered by the Vaccines for Children (VFC) program are not reimbursable for individuals under 19. Please refer to the Medicaid Provider website for the list of VFC vaccines.

Global Days – Global surgery indicator. Global surgery periods are pre- and post-operative time frames assigned to surgical procedures.
000: Same day as procedure
010: Same day and ten days following procedure
090: One day prior to and ninety days following procedure
MMM: In maternity cases, the global period is per the CPT-4 code description
ZZZ: Add-on code, global period does not apply. An add-on code must be billed with its associated primary code
Space: Global concept does not apply to this code

PA – Prior Authorization
Y: Prior authorization is required
Space - this indicator does not apply to this code

Indicators
Mult - Multiple surgery guidelines do apply
Bilat - Bilateral. The procedure can be done bilaterally
Assist - Assistant. An assistant is allowed for this procedure
Co-Surg - Co-Surgery. A co-surgeon is allowed for this procedure
Team - A team of surgeons is allowed for this procedure
Y - Indicator is applicable to this code
Space - this indicator does not apply to this code
Policy Adjust - M = Maternity, F = Family Planning

Montana Medicaid - Fee Schedule
Mid-Level
September 1, 2011

Proc	Mod	Description	Effective	Method	Fees Office	Fees Facility	Global Days	PA	Mult	Bilat	Indicators Assist	Indicators CoSurg	Indicators Team	Policy Adjust
A4206		1 CC STERILE SYRINGE&NEEDLE	7/1/2005	RBRVS	$0.00	$0.00								
A4207		2 CC STERILE SYRINGE&NEEDLE	7/1/2005	RBRVS	$0.00	$0.00								
A4208		3 CC STERILE SYRINGE&NEEDLE	7/1/2005	RBRVS	$0.00	$0.00								
A4209		5+ CC STERILE SYRINGE&NEEDLE	7/1/2005	RBRVS	$0.00	$0.00								
A4211		SUPP FOR SELF-ADM INJECTIONS	7/1/2003	RBRVS	$0.00	$0.00								
A4212		NON CORING NEEDLE OR STYLET	7/1/2003	RBRVS	$0.00	$0.00								
A4213		20+ CC SYRINGE ONLY	7/1/2005	RBRVS	$0.00	$0.00								
A4215		STERILE NEEDLE	7/1/2005	RBRVS	$0.00	$0.00								
A4220		INFUSION PUMP REFILL KIT	10/1/2007	BY REPORT	$0.00	$0.00								
A4244		ALCOHOL OR PEROXIDE PER PINT	7/1/2005	RBRVS	$0.00	$0.00								
A4245		ALCOHOL WIPES PER BOX	7/1/2005	RBRVS	$0.00	$0.00								
A4246		BETADINE/PHISOHEX SOLUTION	7/1/2005	RBRVS	$0.00	$0.00								
A4247		BETADINE/IODINE SWABS/WIPES	7/1/2005	RBRVS	$0.00	$0.00								
A4250		URINE REAGENT STRIPS/TABLETS	7/1/2003	RBRVS	$0.00	$0.00								
A4258		LANCET DEVICE EACH	7/1/2003	RBRVS	$0.00	$0.00								
A4261		CERVICAL CAP CONTRACEPTIVE	7/1/2006	BY REPORT	$0.00	$0.00								
A4262		TEMPORARY TEAR DUCT PLUG	7/1/2003	RBRVS	$0.00	$0.00								
A4263		PERMANENT TEAR DUCT PLUG	7/1/2003	RBRVS	$0.00	$0.00								
A4265		PARAFFIN	7/1/2003	RBRVS	$0.00	$0.00								
A4266		DIAPHRAGM	12/1/2003	FEE SCHED	$45.00	$0.00								
A4267		MALE CONDOM	12/1/2003	FEE SCHED	$45.00	$0.00								
A4268		FEMALE CONDOM	12/1/2003	FEE SCHED	$45.00	$0.00								
A4269		SPERMICIDE	12/1/2003	FEE SCHED	$45.00	$0.00								
A4270		DISPOSABLE ENDOSCOPE SHEATH	7/1/2003	RBRVS	$0.00	$0.00								
A4300		CATH IMPL VASC ACCESS PORTAL	7/1/2003	RBRVS	$0.00	$0.00								
A4305		DRUG DELIVERY SYSTEM >=50 ML	7/1/2003	RBRVS	$0.00	$0.00								
A4306		DRUG DELIVERY SYSTEM <=50 ML	7/1/2003	RBRVS	$0.00	$0.00								
A4310		INSERT TRAY W/O BAG/CATH	7/1/2003	RBRVS	$0.00	$0.00								
A4311		CATHETER W/O BAG 2-WAY LATEX	7/1/2003	RBRVS	$0.00	$0.00								
A4312		CATH W/O BAG 2-WAY SILICONE	7/1/2003	RBRVS	$0.00	$0.00								
A4313		CATHETER W/BAG 3-WAY	7/1/2003	RBRVS	$0.00	$0.00								
A4314		CATH W/DRAINAGE 2-WAY LATEX	7/1/2003	RBRVS	$0.00	$0.00								
A4315		CATH W/DRAINAGE 2-WAY SILCNE	7/1/2003	RBRVS	$0.00	$0.00								
A4316		CATH W/DRAINAGE 3-WAY	7/1/2003	RBRVS	$0.00	$0.00								
A4320		IRRIGATION TRAY	7/1/2003	RBRVS	$0.00	$0.00								
A4321		CATH THERAPEUTIC IRRIG AGENT	7/1/2003	RBRVS	$0.00	$0.00								
A4322		IRRIGATION SYRINGE	7/1/2003	RBRVS	$0.00	$0.00								
A4326		MALE EXTERNAL CATHETER	7/1/2003	RBRVS	$0.00	$0.00								
A4327		FEM URINARY COLLECT DEV CUP	7/1/2003	RBRVS	$0.00	$0.00								
A4328		FEM URINARY COLLECT POUCH	7/1/2003	RBRVS	$0.00	$0.00								

Podiatry definitions

- ARM 37.86.501 contains information specific to the practice of podiatry.

(2) "Podiatry services" means those services provided by individuals licensed under state law to practice podiatry which are within the scope of their practice.

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Medicaid Rules/Regulations

Administrative Rules of Montana (ARM)
Montana Code Annotated (MCA)
Code of Federal Regulations (CFR)

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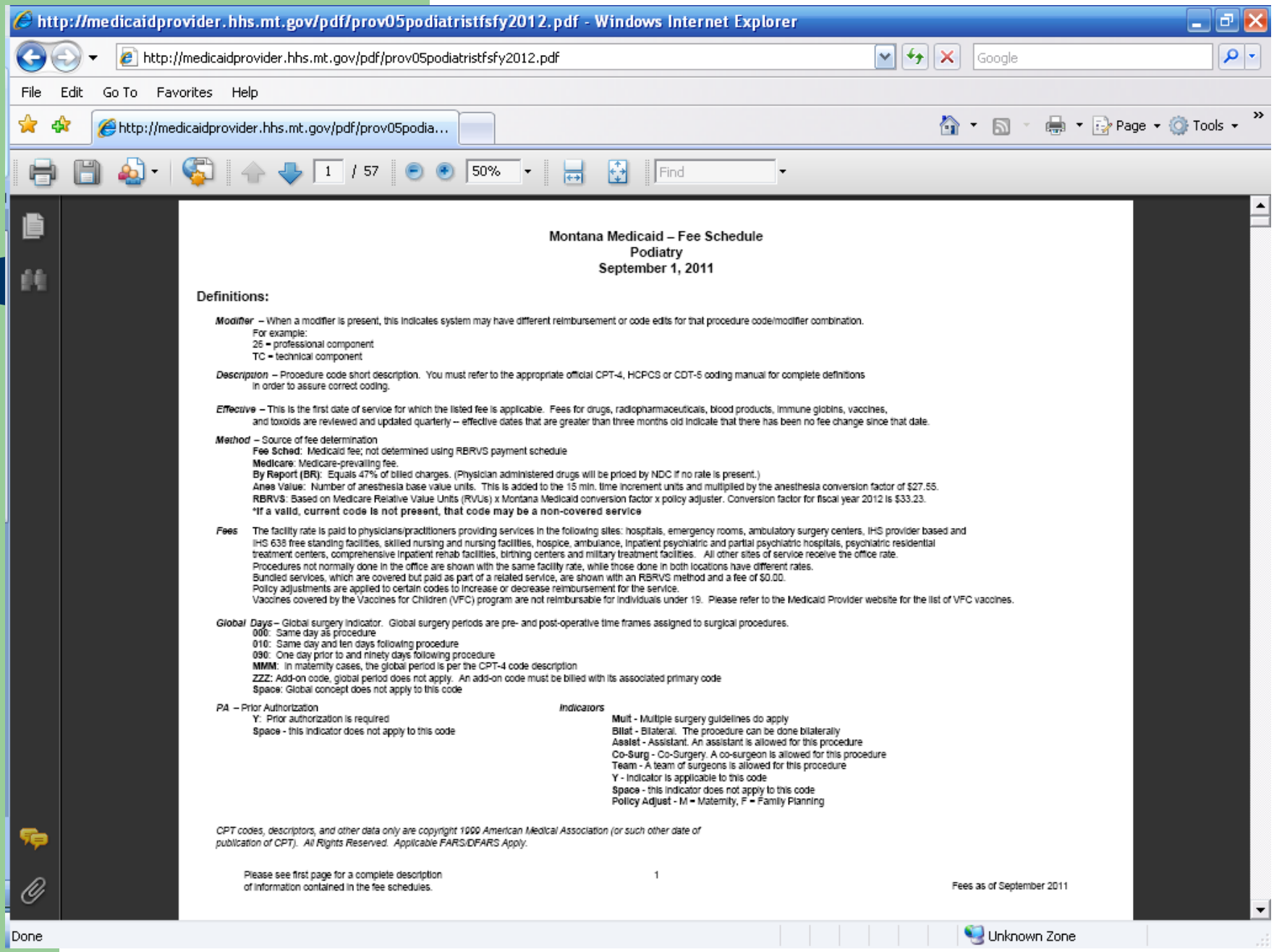

Montana Medicaid – Fee Schedule
Podiatry
September 1, 2011

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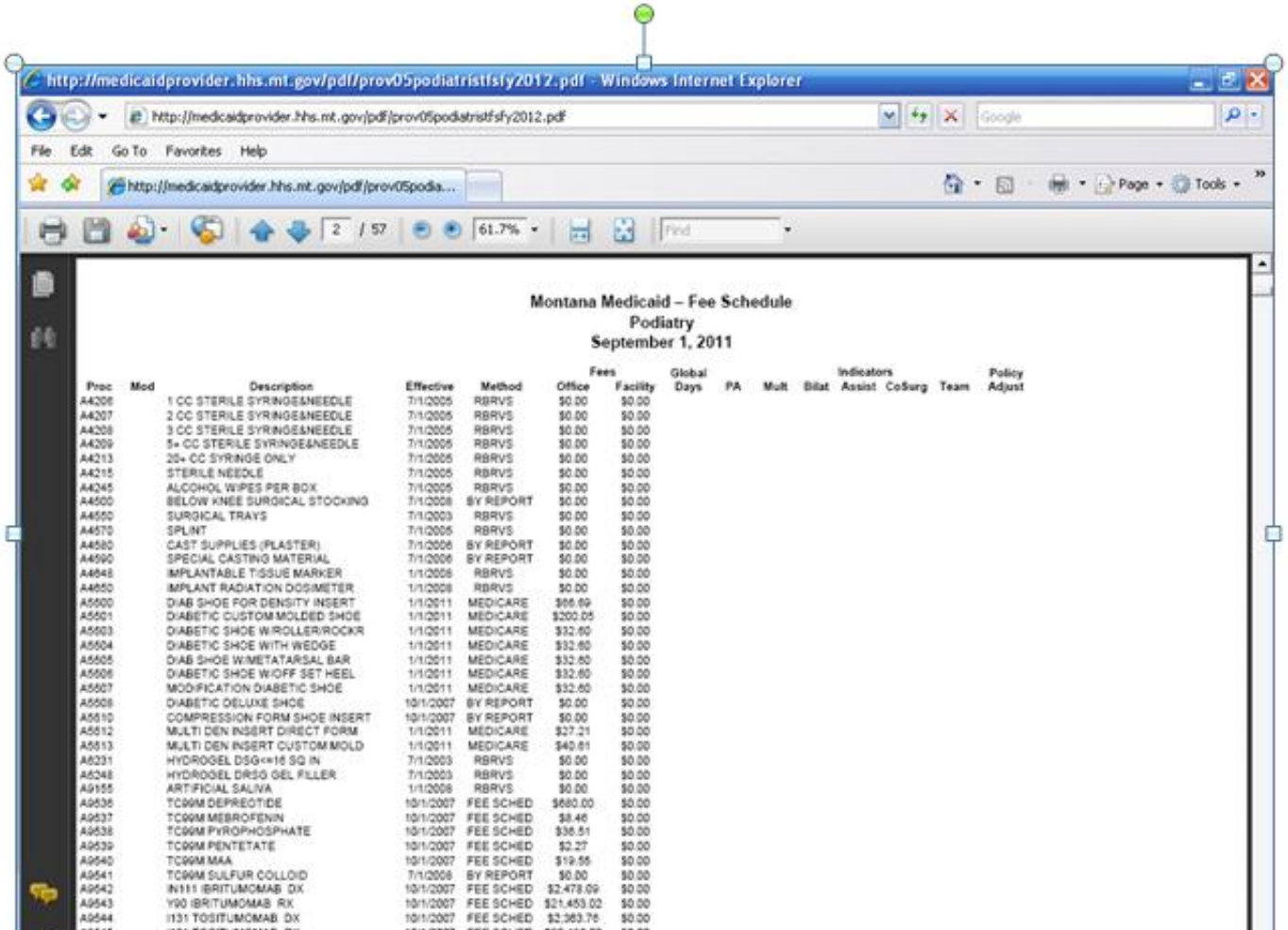
Policy Adjust - M = Maternity, F = Family Planning


http://medicaidprovider.hhs.mt.gov/pdf/prov05podiatristfsfy2012.pdf - Windows Internet Explorer
http://medicaidprovider.hhs.mt.gov/pdf/prov05podiatristfsfy2012.pdf
File Edit Go To Favorites Help
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Proc Mod Description Effective Method Fees Office Fees Facility Global Days PA Mult Bilat Indicators Assist Indicators CoSurg Indicators Team Policy Adjust
A4206 1 CC STERILE SYRINGE&NEEDLE 7/1/2005 RBRVS $0.00 $0.00
A4207 2 CC STERILE SYRINGE&NEEDLE 7/1/2005 RBRVS $0.00 $0.00
A4208 3 CC STERILE SYRINGE&NEEDLE 7/1/2005 RBRVS $0.00 $0.00
A4209 5+ CC STERILE SYRINGE&NEEDLE 7/1/2005 RBRVS $0.00 $0.00
A4213 20+ CC SYRINGE ONLY 7/1/2005 RBRVS $0.00 $0.00
A4215 STERILE NEEDLE 7/1/2005 RBRVS $0.00 $0.00
A4245 ALCOHOL WIPES PER BOX 7/1/2005 RBRVS $0.00 $0.00
A4500 BELOW KNEE SURGICAL STOCKING 7/1/2008 BY REPORT $0.00 $0.00
A4550 SURGICAL TRAYS 7/1/2003 RBRVS $0.00 $0.00
A4570 SPLINT 7/1/2005 RBRVS $0.00 $0.00
A4580 CAST SUPPLIES (PLASTER) 7/1/2006 BY REPORT $0.00 $0.00
A4590 SPECIAL CASTING MATERIAL 7/1/2006 BY REPORT $0.00 $0.00
A4648 IMPLANTABLE TISSUE MARKER 1/1/2008 RBRVS $0.00 $0.00
A4650 IMPLANT RADIATION DOSIMETER 1/1/2008 RBRVS $0.00 $0.00
A5500 DIAB SHOE FOR DENSITY INSERT 1/1/2011 MEDICARE $66.69 $0.00
A5501 DIABETIC CUSTOM MOLDED SHOE 1/1/2011 MEDICARE $200.05 $0.00
A5503 DIABETIC SHOE W/ROLLER/ROCKR 1/1/2011 MEDICARE $32.60 $0.00
A5504 DIABETIC SHOE WITH WEDGE 1/1/2011 MEDICARE $32.60 $0.00
A5505 DIAB SHOE W/METATARSAL BAR 1/1/2011 MEDICARE $32.60 $0.00
A5506 DIABETIC SHOE W/OFF SET HEEL 1/1/2011 MEDICARE $32.60 $0.00
A5507 MODIFICATION DIABETIC SHOE 1/1/2011 MEDICARE $32.60 $0.00
A5508 DIABETIC DELUXE SHOE 10/1/2007 BY REPORT $0.00 $0.00
A5510 COMPRESSION FORM SHOE INSERT 10/1/2007 BY REPORT $0.00 $0.00
A5512 MULTI DEN INSERT DIRECT FORM 1/1/2011 MEDICARE $27.21 $0.00
A5513 MULTI DEN INSERT CUSTOM MOLD 1/1/2011 MEDICARE $40.61 $0.00
A6231 HYDROGEL DSG<=16 SQ IN 7/1/2003 RBRVS $0.00 $0.00
A6248 HYDROGEL DRSG GEL FILLER 7/1/2003 RBRVS $0.00 $0.00
A9155 ARTIFICIAL SALIVA 1/1/2008 RBRVS $0.00 $0.00
A9536 TC99M DEPREOTIDE 10/1/2007 FEE SCHED $680.00 $0.00
A9537 TC99M MEBROFENIN 10/1/2007 FEE SCHED $8.46 $0.00
A9538 TC99M PYROPHOSPHATE 10/1/2007 FEE SCHED $36.51 $0.00
A9539 TC99M PENTETATE 10/1/2007 FEE SCHED $2.27 $0.00
A9540 TC99M MAA 10/1/2007 FEE SCHED $19.55 $0.00
A9541 TC99M SULFUR COLLOID 7/1/2008 BY REPORT $0.00 $0.00
A9542 IN111 IBRITUMOMAB DX 10/1/2007 FEE SCHED $2,478.09 $0.00
A9543 Y90 IBRITUMOMAB RX 10/1/2007 FEE SCHED $21,453.02 $0.00
A9544 I131 TOSITUMOMAB DX 10/1/2007 FEE SCHED $2,363.76 $0.00

Rule References

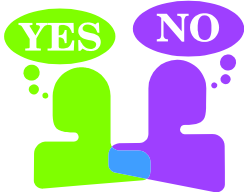
- Providers should familiarize themselves with all current rules and regulations governing the Montana Medicaid program.
- Links to rules are available on the Provider Information website (see *Key Contacts)*
- Provider manuals do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule.

When To Bill Medicaid Clients

ARM 37.85.406

- (11) “Providers are required to accept, as payment in full, the amount paid by the Montana Medicaid program for a service or item provided to an eligible Medicaid recipient in accordance with the rules of the department. Providers shall not seek any payment in addition to or in lieu of the amount paid by the Montana Medicaid program from a recipient or his representative. “

- (b) “Provider may not bill a client after Medicaid has denied payment for covered services because the services are not medically necessary for the recipient.”



Providers may not bill Medicaid clients for services covered under Medicaid

- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment.
- When services are free to the client (i.e. Public health clinic)

Providers **may not** bill Medicaid clients for services covered under Medicaid

- If the patient informed the facility of Medicaid eligibility (unless prior to the services the facility informed the patient that they do no accept Medicaid patients and the patient agreed to pay privately for the services. (signed agreement)

- For the difference between charges and the amount Medicaid allowed.

- For a covered service provided to a Medicaid-enrolled client who was accepted as a Medicaid client by the provider, even if the claim was denied.

EXCEPTIONS

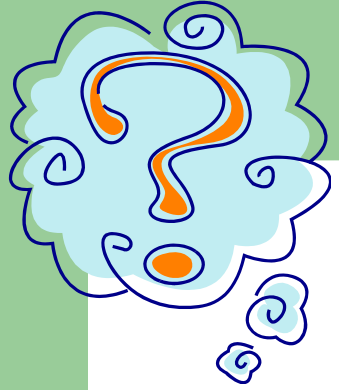
- Providers may collect cost share
- Provider may bill a client for non covered services if the provider has informed the recipient in advance of providing the services that Medicaid will not cover the service

EXCEPTIONS continued

- Provider may bill a client for covered but medically unnecessary services, including services for which Medicaid has denied payment for lack of medical necessity, if the provider specifically informed the recipient in advance of providing the services that the services are not considered medically necessary under Medicaid criteria, that Medicaid will not pay for the services and that the recipient will be required to pay privately for the services, and the recipient has agreed to pay privately for the services. (Specific signed agreement)

FORMS

Can be found in the Physician Manual in Appendix A



QUESTIONS

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Feel free to ask questions or submit them.

Please fill out the evaluation form and provide suggestions on how to improve this training……